No. 100079-1

SUPREME COURT
OF THE STATE OF WASHINGTON

No. 80854-1-I

COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON

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MARI YVONNE DAVIES,
Respondent,

v.

MULTICARE HEALTH SYSTEM, a Washington corporation d/b/a GOOD SAMARITAN HOSPITAL, and MT. RAINIER EMERGENCY PHYSICIANS, PLLC; MICHAEL HIRSIG, M.D,
Petitioners.

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# PETITION FOR REVIEW

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## A. Identity of Petitioners and Decision Below.

Petitioners Dr. Michael Hirsig, Mt. Rainier Emergency Physicians, PLLC, and MultiCare Health System seek review of Division One's July 12, 2021 decision reversing the trial court's dismissal of respondent Mari Davies' informed consent claim, published at *Davies v. MultiCare Health Sys.*, ___ Wn. App.2d ___, 2021 WL 2909042 (July 12, 2021) (Appendix).

Dr. Hirsig treated Ms. Davies in the Emergency Department at MultiCare's Good Samaritan Hospital for injuries sustained in a car accident. After consulting with a MultiCare neurosurgeon, Dr. Hirsig determined that Ms. Davies' stable, non-displaced, non-operative cervical spine fracture did not require hospitalization or further tests before discharge. The next day, Ms. Davies suffered a stroke, allegedly caused by an undiagnosed vertebral artery dissection. Ms. Davies alleged that by failing to order a computed tomography angiography ("CTA") study or inform her that this diagnostic procedure could have detected a vertebral artery injury, Dr. Hirsig both violated the standard of care and breached his duty of informed consent. After the trial court dismissed Ms. Davies' informed consent claim on summary judgment, a jury found that Dr. Hirsig's decision not to order a CTA because he had ruled out a

vertebral artery injury after consulting with a neurosurgeon complied with the standard of care.

The Court of Appeals affirmed the defense verdict on Ms. Davies' medical negligence claim but reinstated the informed consent claim on the ground that "Davies was never advised of the risk of a vertebral artery dissection or the availability of a CTA scan to look for the injury which would have led to a different treatment." (Op. ¶ 30)[1] The Court of Appeals' published decision conflicts with settled law that "a provider cannot be liable for failure to inform in a misdiagnosis case." *Anaya Gomez v. Sauerwein*, 180 Wn.2d 610, 618, ¶ 19, 331 P.3d 19 (2014). The Court of Appeals upended this Court's clear guidance to Washington health care providers and patients that the failure to diagnose a condition may support a claim of medical negligence, but not an informed consent claim, which is based on the right to know the risks and alternatives for *treatment* of a condition that the physician has actually diagnosed, not one the physician has ruled out. This Court should accept review under RAP 13.4(b)(1), (2) and (4), reverse the Court of Appeals, and reinstate the trial court's judgment of dismissal.

[1] Citations in this petition for review are to the numbered paragraphs of the published decision attached as the Appendix.

## B. Issues Presented for Review.

A patient alleged that defendant physician failed to diagnose a condition and failed to inform her of a test that could have identified the condition that the physician had ruled out. This Court held in *Anaya Gomez v. Sauerwein*, 180 Wn.2d 610, 331 P.3d 19 (2014), that "a provider cannot be liable for failure to inform in a misdiagnosis case," because "a health care provider who believes the patient does not have a particular disease cannot be expected to inform the patient about the unknown disease or possible treatments for it." Did the Court of Appeals err in reinstating the patient's informed consent claim when the jury rejected her medical negligence claim based on the physician's alleged misdiagnosis?

## C. Statement of the Case.

Mari Davies ran off the road and rolled her car on August 23, 2017. (CP 170) The responding EMTs placed Ms. Davies on a backboard and in a cervical collar and transported her to Multicare's Good Samaritan Emergency Department, where she was met immediately upon arrival by nursing staff and treating emergency medicine physician Dr. Hirsig. (CP 170-71) Ms. Davies complained of a headache and "all-over body pain," but had no difficulty speaking

or with her vision, and told Dr. Hirsig that tingling in her left arm she had reported to the EMTs had resolved. (CP 172, 175)

Dr. Hirsig took Ms. Davies' extensive medical history, performed a physical examination, and ordered CT scans of her head, cervical spine, abdomen and pelvis. (Op. ¶ 3; CP 576) Dr. Hirsig consulted with radiologist Dr. Scott Henneman, who reviewed the CT scans and reported fractures of the cervical spine at C3. (Op. ¶ 3) Dr. Hirsig then consulted with MultiCare neurosurgeon Dr. William Morris, who reviewed the CT scans, confirmed the fractures at C3 level, and told Dr. Hirsig the fractures appeared stable and would not require surgery and that Ms. Davies could be treated with a hard cervical collar. (Op. ¶ 3; CP 177, 571)

It was undisputed that Dr. Hirsig concluded that Ms. Davies "had nothing that led me to believe or suspect that she had a [vertebral artery] dissection" (CP 577) and ruled out a vertebral artery injury in his differential diagnosis:

> Q. Did you consider a vertebral artery injury in your differential diagnosis for this - -
>
> . . .
>
> A. Yeah. Absolutely. I mean, I considered all types of injuries. I mean, she could have had a vertebral artery dissection. She could have had a head bleed. She could have had a pneumothorax, rib fractures, hip fractures. So, yeah, I had to consider all of that.

. . .

> [I]n my judgment, at that time, her clinical picture did not lead me to suspect that she had a dissection. She had no signs or symptoms of it.
>
> . . .
>
> [U]sually you will see a little bit of vertigo. They will have maybe some nystagmus. They'll have a Horner's syndrome. They will have inability to stand, loss of balance. They can have blurred vision, facial pain, ear pain. They can have swelling in the throat or in the neck.

(CP 577-58) Because he saw no clinical indications supporting further testing, Dr. Hirsig did not order CTA imaging of the cervical arterial vessels. (CP 576-77)[2]

After his consultation with Dr. Morris, Dr. Hirsig re-examined Ms. Davies and confirmed that she could stand, that her pain had subsided, and that her blood pressure had decreased. (CP 571-72) He determined that she did not have any other traumatic injuries or neurological symptoms that required hospitalization. Dr. Hirsig told Ms. Davies she had suffered a non-operative neck fracture and did

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[2] Computed tomography angiography ("CTA") is a special type of CT scan in which contrast dye is injected into the patient's bloodstream. CTA can aid examination of the blood vessels and diagnosis of vertebral artery injury. (CP 577) At trial, a primary factual issue was whether the standard of care required a CTA in all instances of cervical fracture. (RP 940-41, 2165-70) The jury found it did not, returning a verdict for Dr. Hirsig on Ms. Davies' medical negligence claim. (CP 823)

not need to be hospitalized. After determining that Ms. Davies could be discharged in a hard cervical collar with follow-up on an outpatient basis, and after discussing his diagnosis and treatment plan with Ms. Davies and family members present in the Emergency Department, Dr. Hirsig discharged Ms. Davies. (CP 72, 177-78, 571)

The next day, while following up with her primary care physician at MultiCare, Ms. Davies' condition suddenly worsened. Her physician arranged for immediate ambulance transfer to the hospital, where Ms. Davis was diagnosed with a stroke. (CP 167, 193)

Ms. Davies claimed that Dr. Hirsig breached both the standard of care of a reasonably prudent emergency room physician and the duty to obtain informed consent by failing to order or to offer a CTA scan before discharging Ms. Davies, alleging a CTA scan would have revealed a dissection that would have led to hospital admission and treatment to prevent her stroke. (CP 2-3, 92) On cross-motions for partial summary judgment, King County Superior Court Judge Regina Cahan ("the trial court") dismissed plaintiff's informed consent claim. (CP 706-08) After hearing testimony that the standard of care does not mandate a CTA scan in every case of cervical fracture, and that Ms. Davies presented with none of the symptoms that placed her at increased risk of a vertebral artery

dissection (RP 2165-70), a 12-person jury found Dr. Hirsig did not breach the standard of care, and, as a consequence, did not reach the issue of proximate cause on the special verdict form. (CP 823-25)[3]

The Court of Appeals affirmed the medical negligence verdict but reversed the partial summary judgment, remanding for trial on informed consent. The court held that Ms. Davies had the right under Washington's informed consent statute to be advised that a CTA scan could have led to diagnosis of a vertebral artery dissection that she claimed later caused her stroke: "Davies was never advised of the risk of a vertebral artery dissection or that availability of a CTA scan to look for the injury which would have led to a different treatment." (Op. ¶ 30)

**D. Why This Court Should Grant Review.**

Washington informed consent law, as interpreted by this Court and each division of the Court of Appeals, requires that a physician advise a patient of the risks and alternatives to treatment

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[3] Ms. Davies had also sued consulting neurosurgeon Dr. Morris for breach of the standard of care. Like Dr. Hirsig, the jury found that he was not negligent (CP 785, 823), based on testimony that Dr. Morris specifically looked for and did not identify any fracture through the transverse foramen, which would increase the risk of vertebral artery dissection, and that Ms. Davies' fracture was stable, a further indication that there was a low risk of dissection, which occurs in perhaps 0.1% of neck fractures. (RP 760, 1009, 1173, 1179-80)

for a condition that the physician has diagnosed, not diagnostic tests for a condition the physician has ruled out. RAP 13.4(b)(1), (2). "[I]nformed consent and medical negligence are distinct claims. . . [and] two different theories of recovery" (Op. ¶ 16), quoting *Anaya Gomez v. Sauerwein,* 180 Wn.2d 610, 617, 331 P.3d 19 (2014). A physician's misdiagnosis, or failure to diagnose, a condition presents an issue of medical negligence, not informed consent.

The Court of Appeals' published decision in this case upends that clear statutory and case law, imposing upon physicians an obligation to offer patients—and upon patients the burden of choosing whether to submit to—expensive and potentially invasive procedures to detect a condition that the physician, in the exercise of medical judgment, has ruled out. This Court should accept review to correct this needless confusion of the principles governing informed consent and medical negligence claims. RAP 13.4(b)(4).

**1. The Court of Appeals' published decision imposes a duty on physicians to inform patients of diagnostic procedures for conditions that the physician has ruled out, in conflict with *Anaya Gomez* and a host of Court of Appeals' decisions.** (RAP 13.4(b)(1), (2))

The doctrine of informed consent is "based on the policy judgment that patients have the right to make decisions about their own medical treatment." *Backlund v. University of Washington,* 137

Wn.2d 651, 662, 975 P.2d 950 (1999). RCW 7.70.030-.060 have governed informed consent claims since 1976. The plaintiff must establish that (1) a "health care provider failed to inform the patient of a material fact or facts relating to *the treatment*;" (2) the patient consented to *the treatment* without being aware of or fully informed of such material fact or facts;" (3) "that a reasonably prudent patient under similar circumstances would not have consented to *the treatment* if informed of such material fact or facts;" and (4) "that *the treatment* in question proximately caused injury to the patient." RCW 7.70.050(1)(a)–(d) (emphasis added).

The informed consent doctrine is based on "the patient's right to know" the risks and alternatives attendant to a physician's treatment—not the accuracy or reasonableness of the physician's diagnosis. *Backlund,* 137 Wn.2d at 660; *Burnet v. Spokane Ambulance,* 54 Wn. App. 162, 169, 772 P.2d 1027, *rev. denied,* 113 Wn.2d 1005 (1989). While the Court of Appeals correctly noted that the doctrine of informed consent is grounded in the policy that patients make "intelligent decisions" (Op. ¶ 17), those decisions concern "their medical treatment," not the physician's diagnosis. As this Court recognized in *Anaya Gomez,* by its use of the word "treatment," the Legislature expressed "the intent to limit informed

consent claims to treatment situations," as distinct from the "fundamentally different situation[]" of a physician's diagnosis of the patient's condition:

> Simply put, a health care provider who believes the patient does not have a particular disease cannot be expected to inform the patient about the unknown disease or possible treatments for it. In such situations, a negligence claim for medical malpractice will provide the patient compensation if the provider failed to adhere to the standard of care in misdiagnosing or failing to diagnose the patient's condition.

180 Wn. 2d at 617-18, ¶¶ 16-17, quoting *Backlund*, 137 Wn.2d at 661.

This Court has thus clearly and definitively drawn the line between a physician's misdiagnosis, actionable as a breach of the standard of care, and the physician's breach of the separate duty under RCW 7.70.050 to inform the patient regarding the risks and benefits of treatment for the *correct* diagnosis. "The duty to disclose does not arise until the physician becomes aware of the condition by diagnosing it." *Anaya Gomez*, 180 Wn.2d at 618-19, ¶ 19, quoting *Bays v. St. Lukes Hosp.*, 63 Wn. App. 876, 881, 825 P.2d 319, *rev. denied*, 119 Wn.2d 1008 (1992). "[A] provider cannot be liable for failure to inform in a misdiagnosis case." *Anaya Gomez*, 180 Wn.2d at 618, ¶ 19. A "physician who misdiagnoses the patient's condition, and is therefore unaware of an appropriate category of treatments or treatment alternatives, may properly be subject to a negligence

action where such misdiagnosis breaches the standard of care, but may not be subject to an action based on failure to secure informed consent." *Backlund,* 137 Wn.2d at 659, 661.

The facts of both *Backlund* and *Anaya Gomez* illustrate this distinction between a physician's misdiagnosis and a physician's failure to inform the patient of options concerning a diagnosed condition. In *Backlund,* the defendant physician correctly diagnosed an infant with jaundice, prescribed phototherapy, but did not discuss an alternate blood transfusion treatment with the infant's parents. Plaintiffs stated a valid claim under RCW 7.70.050 because the physician correctly diagnosed the condition but did not advise the parents of the risks and benefits of the alternative transfusion treatment. *Backlund,* 137 Wn.2d at 662.

In *Anaya Gomez,* in contrast, plaintiff claimed an emergency room physician failed to disclose blood cultures the physician had discounted as false positives, leading to the failure to diagnose a fatal yeast infection. This Court held that the plaintiff had no claim for informed consent based on the failure to disclose information relating to the undiagnosed infection: "Either Dr. Sauerwein knew that Mrs. Anaya had a yeast infection, giving rise to a failure to

inform claim, or he failed to know she had a yeast infection, giving rise to a negligence claim." *Anaya Gomez*, 180 Wn.2d at 619, ¶ 21.

Published decisions from the Court of Appeals uniformly adhere to this well-established rule articulated in *Anaya Gomez*: "[A] physician's failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform." *Gustav v. Seattle Urological Assocs.*, 90 Wn. App. 785, 790, 954 P.2d 319, *rev. denied*, 136 Wn.2d 1023 (1998).[4] The Court of Appeals' published decision reinstating Ms. Davies' informed consent claim on the ground that "Davies was never advised of the risk of a vertebral artery dissection or the availability of a CTA scan to look for the injury" (Op. ¶ 30) that Dr. Hirsig had ruled out in his differential diagnosis conflicts with this established case law. RAP 13.4(b)(1) and (2).

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[4] *See, e.g., Harbottle v. Braun*, 10 Wn. App.2d 374, 393, ¶ 48, 447 P.3d 654 (2019) (physician who treated patient for gastroesophageal reflux disease and failed to inform patient of risks of coronary disease, not liable for failing to obtain informed consent), *rev. denied*, 194 Wn.2d 1018 (2020); *Thomas v. Wilfac, Inc.*, 65 Wn. App. 255, 261, 828 P.2d 597, *rev. denied*, 119 Wn.2d 1020 (1992) ("Failure to diagnose a condition is a matter of medical negligence, not a violation of the duty to inform a patient."); *Bays*, 63 Wn. App. at 881-82 (physician had no informed consent duty to discuss possible methods for treating thromboembolism when he was "unaware of the thromboembolism condition."); *Burnet*, 54 Wn. App. at 168-69, (physician did not have a "duty to inform of his decision not to provide any diagnostic tests or treatment" when physician "was unaware of the risk of brain herniation and subsequent injury.").

### 2. The Court of Appeals' published decision will impose significant burdens on both the medical profession and on patients, leading to needless and potentially harmful diagnostic procedures for conditions the physician has ruled out. (RAP 13.4(b)(4))

Contrary to the well-established law that now governs informed consent and medical negligence claims, the Court of Appeals' published decision creates significant confusion regarding the scope of a physician's duty to obtain a patient's informed consent. In its attempt to champion patient sovereignty, the Court of Appeals' published decision will instead endanger patients, encouraging patients to make the decision to opt for expensive, invasive, and risky diagnostic procedures on the off chance that further testing will reveal a condition that their physician, exercising professional judgment, has ruled out.

A health care provider—particularly an emergency room physician—cannot possibly inform a patient of every disease or condition that a patient might have, or of each and every diagnostic procedure that could detect a condition that the provider has ruled out after consulting with a team of specialists. This does not leave that patient without a remedy; the provider's misdiagnosis will be actionable as negligence if it falls short of the care and skill commensurate with his or her discipline. But making a provider's

failure to diagnose a question of the "patient's right to know" as well, as the Court of Appeals' published decision does in this case, significantly, and needlessly, confuses the duties and responsibilities of Washington health care providers and patients.

As the Legislature has recognized, much of modern health care is already driven by unnecessary diagnostic testing.[5] Setting aside the financial impact on patients, their insurers, the rate-paying public, and taxpayers, patients risk actual physical harm if given the option and the obligation to decide whether to undergo diagnostic procedures to explore each and every possible illness. In this case, for instance, Ms. Davies was allergic to the contrast dye routinely used in CTA scans (CP 85), which would also expose her to additional radiation. Many other procedures are far more intrusive and risky.

Under the guise of protecting the patient's right to know, the decision here poses a risk to patient health and safety. By imposing upon physicians the obligation to discuss and offer their patients the

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[5] *See, e.g.* RCW 41.05.021(1)(b)(vi)(B)(II) (State health care authority directed to "reduce unnecessary duplication of medical tests"); RCW 43.06.155(1)(b) (guiding principle of health care reform to reduce "unnecessary tests and services, and other inefficiencies that drive up costs with no added health benefits"); RCW 70.168.010(4) (stated goal of statewide trauma care system to "contain costs of trauma care"). Reducing "rising medical care costs" was the basis for the Legislature's enactment of RCW ch. 7.70. 1976 Final Legislative Report, 44th Wash. Leg. 2nd Ex. Sess., at 22.

choice to undergo a host of alternative diagnostic procedures for a condition the physician has ruled out, the Court of Appeals decision presents an issue of substantial public concern that should be decided by this Court. RAP 13.4(b)(4).

### 3. In reinstating an informed consent claim for the physician's failure to diagnose, the Court of Appeals misplaced its reliance on *Gates*.

The Court of Appeals in particular erred in relying on *Gates v. Jensen,* 92 Wn.2d 246, 595 P.2d 919 (1979) (Op. ¶ 30) to reinstate Ms. Davies' claim that she had the right to know and decide whether to undergo a CTA scan—first, because *Gates* considered a common law informed consent claim arising before the enactment of RCW 7.70.050, and second, because this Court has limited *Gates* to its unique facts: borderline test results in a patient with a long history of symptoms that put her at high risk of illness, and the availability of additional testing that was both inexpensive and free of risk.

In *Gates,* the patient's eye pressure readings were borderline for glaucoma, but after checking her optic nerves her ophthalmologist concluded the patient had problems with her contact lenses. 92 Wn.2d at 247-48. The physician told the patient he had checked for glaucoma but neither informed her of the high readings nor disclosed two simple, free, and readily available tests for the condition.

This Court held these facts could support a common law informed consent claim because "[t]he patient's right to know is not confined to the choice of treatment once a disease is present and has been conclusively diagnosed," but also "[i]mportant decisions . . . in many non-treatment situations . . . including procedures leading to diagnosis." *Gates*, 92 Wn.2d at 250-51. The Court went on to hold that the physician could be liable for negligence regardless whether the standard of care required further testing because the case presented "the same unusual features" as *Helling v. Carey*, 83 Wn.2d 514, 519 P.2d 981 (1974): "a high risk of glaucoma" and "simple, inexpensive, conclusive and risk free" tests. *Gates*, 92 Wn.2d at 253.

The Court of Appeals here paid lip service to the fact that *Gates* was decided before the Legislature codified informed consent as a "treatment-based" doctrine in 1976 (Arg. D.1, *supra* at 9), as well as to this Court's characterization of *Gates* as a "unique factual situation" in *Anaya Gomez*. (Op. ¶¶ 18, 26) By nevertheless resurrecting *Gates* as the basis for reinstating Ms. Davies' informed consent claim, however, the Court of Appeals utterly failed to recognize that, unlike in *Gates*, Ms. Davies did not present with an undiagnosed "abnormal condition," or with a "high risk of disease"—Ms. Davies presented with *no* signs of vertebral artery dissection, and

Dr. Hirsig, after consulting with a radiologist and a neurologist, ruled out the condition given the nature of her fracture. In particular, the Court of Appeals' conclusion that dissection was a "common" occurrence in neck fractures was based solely on the deposition testimony of Ms. Davies' experts that Dr. Hirsig "should have" looked for a vertebral artery injury under the governing standard of care (CP 92, 143, 145), further demonstrating the court's confusion over the standards governing negligence and informed consent claims. (Op. ¶¶ 27-29)[6]

Further, unlike the ophthalmologist in *Gates*, who was aware of his patient's borderline glaucoma readings for two years, 92 Wn.2d at 248, Dr. Hirsig was an emergency physician who had no preexisting relationship with Ms. Davies. Even before the Legislature codified the informed consent doctrine in RCW 7.70.030-.060, this Court recognized the necessarily limited duty of informed consent in the exigencies of emergency medicine. *See Keogan v. Holy Fam. Hosp.*, 95 Wn.2d 306, 316, 622 P.2d 1246 (1980). And here, the "alternative diagnostic procedure" is not

[6] There was no other basis for the Court of Appeals' characterization of this condition as "common." Plaintiff's expert, Dr. Tibbles, could not quantify the frequency of a dissection in her deposition. (CP 421-22) At trial, where the jury exonerated Dr. Hirsig of negligence, Dr. Tibbles quantified the risk at 1 in 1000, or .1%. (RP 1001-02)

"simple, inexpensive, and risk free," like the glaucoma tests in *Gates,* 92 Wn.2d at 248, or even like the noninvasive reculturing of the patient's blood sample that the physician could have ordered in *Anaya Gomez,* 180 Wn.2d at 630, ¶ 43 (Gonzalez, J., concurring).[7]

Ignoring these significant distinctions, the Court of Appeals characterized the CTA scan only as one of "additional tests available as part of her initial diagnoses" of a cervical fracture. (Op. ¶ 27) Leaving aside that Ms. Davies herself repeatedly characterized vertebral artery dissection as a separate diagnosis (CP 506, 512), there were a host of conditions "closely related" to Ms. Davies' stable, non-operative fracture, and even more tests available to Dr. Hirsig to determine whether she was suffering from any of those conditions:

> I mean, I considered all types of injuries. I mean, she could have had a vertebral artery dissection. She could have had a head bleed. She could have had a pneumothorax, rib fractures, hip fractures.

(CP 577)

This Court called *Gates* a case "the likes of which it is unlikely we will ever see . . . again" in *Anaya Gomez,* 180Wn.2d at 626, ¶ 37.

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[7] The parties did not develop these facts on summary judgment, but the jury heard evidence of the risks and costs of a CTA scan. (RP 762, 809-11, 2169) The average price of a cervical CTA in Seattle varies from $1,450 to $3,800. https://www.newchoicehealth.com/procedures/ct-angiography-neck (last accessed, August 9, 2021)

In holding that Ms. Davies' claim was nevertheless governed by *Gates,* the Court of Appeals ignored that it was Dr. Hirsig's failure to inform his patient of invasive diagnostic procedures for a condition he had ruled out that is a "common," not a "unique" or exceptional, scenario in any hospital emergency room.

Further, in relying on *Gates* the Court of Appeals ignored the examples this Court provided in both *Backlund* and *Anaya Gomez* to conclude that while the failure to diagnose a medical condition is actionable as negligence, the failure to advise the patient of the availability of diagnostic tests for an undiagnosed condition is not a breach of the duty of informed consent:

> For example, a physician who misdiagnosed a headache as a transitory problem and failed to detect a brain tumor may be guilty of negligence for the misdiagnosis, but it seems anomalous to hold the physician culpable . . . for failing to secure the patient's informed consent for treatment for the undetected tumor.

*Backlund*, 137 Wn.2d at 661, n.2. *Accord, Anaya Gomez*, 180 Wn.2d at 623, ¶ 30, n.8 (analogizing to failure to diagnose a heart attack: "'[there are] 200 different things that might cause chest pain, only 3 of which related to the heart,'" quoting *Keogan*, 95 Wn.2d at 330 (Hicks, J., concurring in part, dissenting in part)).

The Court of Appeals' decision cannot be squared with this Court's conclusion that "*Gates* is the exception and not the rule with

regard to the overlap between medical negligence and informed consent" in *Anaya Gomez,* 180 Wn.2d at 626, ¶ 37. RAP 13.4(b)(1).

**E. Conclusion.**

This Court in *Anaya Gomez* clearly distinguished between a physician's duty to comply with the standard of care in diagnosing a patient's condition and the physician's duty to obtain the patient's informed consent, which gives the patient the right to know the risks and benefits of treatment once the physician has made a correct diagnosis. The Court of Appeals' published decision obliterates that distinction, in conflict with this Court's guidance to the health care profession and patients in *Anaya Gomez.* This Court should accept review and reinstate the trial court's judgment.

Dated this 10th day of August, 2021.

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Attorneys for Petitioners

## DECLARATION OF SERVICE

The undersigned declares under penalty of perjury, under the laws of the State of Washington, that the following is true and correct:

That on August 10, 2021, I arranged for service of the foregoing Petition for Review, to the Court and to the parties to this action as follows:

| | |
|---|---|
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**DATED** at Seattle, Washington this 10th day of August, 2021.

Andrienne E. Pilapil

2021 WL 2909042
Only the Westlaw citation is currently available.
Court of Appeals of Washington, Division 1.

Mari Yvonne DAVIES, Appellant,
v.
MULTICARE HEALTH SYSTEM, a Washington corporation d/b/a Good Samaritan Hospital, and Mt. Rainier Emergency Physicians, PLLC; Michael Hirsig, M.D., Respondents.

No. 80854-1-I
|
FILED 7/12/2021

**Synopsis**

**Background:** Emergency room patient who suffered a stroke caused by a vertebral artery dissection after being discharged from hospital brought action against hospital, emergency room attending physician, and physician's employer, alleging medical negligence and failure to obtain informed consent. The Superior Court, King County, Regina S. Cahan, J., granted summary judgment on the issue of informed consent and entered judgment as to her negligence claim, on jury's verdict, against patient. Patient appealed.

**Holdings:** The Court of Appeals, Mann, C.J., held that:

[1] factual issue existed as to whether physician had duty to inform patient, that there were additional tests available as part of her initial diagnoses, thus, precluding summary judgment on patient's informed consent claim;

[2] evidence supported issuance of exercise of judgment instruction in medical malpractice action;

[3] neurosurgeon had sufficient expertise to testify regarding the standard of care for physician's decision to not order a CT angiography (CTA) scan; but

[4] any error in trial court's decision to exclude neurosurgeon's expert testimony was harmless.

Affirmed in part, reversed in part, and remanded.

**Procedural Posture(s):** On Appeal; Motion for Summary Judgment.

West Headnotes (20)

[1] **Health** Elements of malpractice or negligence in general

**Health** Informed consent in general; duty to disclose

Informed consent and medical negligence are distinct claims that apply in different situations; while there is some overlap, they are two different theories of recovery with independent rationales.

[2] **Health** Informed consent in general; duty to disclose

"Informed consent" allows a patient to recover damages from a physician even though the medical diagnosis or treatment was not negligent. Wash. Rev. Code Ann. § 7.70.050(1).

[3] **Health** Informed consent in general; duty to disclose

The informed consent statute is generally based on the policy judgment that patients have the right to make decisions about their own medical treatment; a necessary corollary to this principle is that the individual be given sufficient information to make an intelligent decision. Wash. Rev. Code Ann. § 7.70.050(1).

[4] **Health** Informed consent in general; duty to disclose

In informed consent cases, it is for the patient to evaluate risks of treatment and the only role to be played by physician is to provide that patient with information as to what those risks are. Wash. Rev. Code Ann. § 7.70.050(1).



Appendix

[5] **Judgment** Tort cases in general

Genuine issue of material fact existed as to whether emergency room physician had duty to inform patient, who had been diagnosed with a cervical fracture and who later suffered a stroke caused by a vertebral artery dissection, that there were additional tests available as part of her initial diagnoses, namely, a CT angiography (CTA) scan, to check for vertebral artery dissection prior to discharge from hospital, thus, precluding summary judgment on patient's informed consent claim against physician and hospital. Wash. Rev. Code Ann. § 7.70.050(1).

[6] **Health** Informed consent in general; duty to disclose

In an informed consent case, the determining factor for whether a physician had a duty to inform is whether the process of diagnosis presents an informed decision for the patient to make about his or her care. Wash. Rev. Code Ann. § 7.70.050(1).

[7] **Health** Instructions

Evidence supported issuance of exercise of judgment instruction in medical malpractice action by patient who suffered a stroke caused by a vertebral artery dissection after being discharged from hospital against physician, and hospital; attending emergency room physician testified that he considered possibility that patient could have a vertebral artery dissection, that he learned from neuroradiologist that patient had a cervical spine fracture but that neuroradiologist did not identify a transverse foramen fracture, and that consequently, he chose not to request a CTA, neurosurgeon testified that in consulting with physician he looked for a transverse foramen fracture but observed none, and defense experts testified that both physicians met standard of care in not ordering a CTA scan.

[8] **Appeal and Error** Health care and medical insurance

The Court of Appeals reviews a decision on whether to give an exercise of judgment instruction in a medical negligence case for abuse of discretion; this is a fact specific inquiry.

[9] **Trial** Sufficiency as to Subject-Matter

**Trial** Facts and Evidence

**Trial** Construction and Effect of Charge as a Whole

Jury instructions are generally sufficient if they: (1) are supported by the evidence; (2) allow each party to argue its theory of the case; and (3) properly inform the trier of fact of the applicable law when all the instructions are read together.

[10] **Health** Instructions

A court should give an exercise of judgment instruction, providing physician is not liable for selecting one of two or more alternative courses of treatment/diagnoses if physician exercised reasonable care and skill within applicable standard of care, only when the physician presents sufficient evidence that they made a choice between two or more alternative, reasonable and medically acceptable treatment plans or diagnoses.

[11] **Evidence** Due care and proper conduct in general

Neurosurgeon had sufficient expertise to testify regarding the standard of care for emergency room attending physician's decision to not order a CT angiography (CTA) scan, in medical malpractice action brought by patient, who suffered a stroke caused by a vertebral artery dissection after being discharged from hospital, against physician and hospital; neurosurgeon had completed a cerebrovascular fellowship, including work regarding the vertebral artery, and she had substantial emergency room experience, including the care and treatment of patients with neck fractures and the decision to

  

order a CTA scan. Wash. Rev. Code Ann. § 7.70.040(1).

[12] **Appeal and Error** ⇐ Expert Evidence and Witnesses

Appellate court reviews the decision to exclude an expert witness's testimony for abuse of discretion.

[13] **Health** ⇐ Standard of practice and departure therefrom

**Health** ⇐ Proximate cause

Expert testimony will generally be necessary to establish standard of care and proximate cause required in medical malpractice cases.

[14] **Evidence** ⇐ Due care and proper conduct in general

Only experts who practice in the same field or have expertise in the relevant specialty may establish the standard of care in a medical malpractice case. Wash. Rev. Code Ann. § 7.70.040(1).

[15] **Evidence** ⇐ Knowledge, experience, and skill in general

The scope of an expert's knowledge, not his or her professional title, should govern the threshold question of admissibility of expert medical testimony in a malpractice case. Wash. Rev. Code Ann. § 7.70.040.

[16] **Evidence** ⇐ Knowledge, experience, and skill in general

A physician with a medical degree is qualified to express an opinion on any sort of medical question, including questions in areas in which the physician is not a specialist, so long as the physician has sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue in the medical malpractice action. Wash. Rev. Code Ann. § 7.70.040.

[17] **Evidence** ⇐ Due care and proper conduct in general

When standard-of-care experts are from a different school of medicine, the testimony should be allowed in a medical malpractice case (1) where the methods of treatment in the defendant's school and the school of the witness are the same, (2) where the method of treatment in the defendant's school and the school of the witness should be the same, or (3) the testimony of a witness is based on knowledge of the defendant's own school. Wash. Rev. Code Ann. § 7.70.040.

[18] **Appeal and Error** ⇐ Expert evidence

Any error in trial court's decision to exclude neurosurgeon's expert testimony regarding the standard of care for emergency room attending physician's decision to not order a CT angiography (CTA) scan, was harmless in medical malpractice action brought by patient, who suffered a stroke caused by a vertebral artery dissection after being discharged from hospital, against physician and hospital; patient's counsel stated that neurosurgeon would have testified that physician should not have discharged patient due to the mechanism of her injury and the other clinical problems, however, patient's emergency medicine expert testified extensively as to her opinion that patient was not safe to go home and should not have been discharged, such that the excluded testimony was cumulative. Wash. Rev. Code Ann. § 7.70.040(1).

[19] **Appeal and Error** ⇐ Relation Between Error and Final Outcome or Result

Test for harmless error is whether there is reasonable probability that an error materially affected the outcome of trial.

[20] **Appeal and Error** ⇐ Same or Similar Evidence Otherwise Admitted; Cumulative Evidence

A factor to consider when determining harmless error is whether excluded evidence involved cumulative evidence.

Honorable Regina Cahan, Judge

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PUBLISHED OPINION

Mann, C.J.

***1** ¶1 In this medical malpractice action, Mari Davies appeals the trial court's order dismissing her informed consent claim on summary judgment. Davies also appeals the judgment entered on a jury verdict finding the defendants not negligent. Davies argues that the trial court erred by giving an exercise of judgment jury instruction, and preventing her expert neurosurgeon from testifying at trial regarding the standard of care for an emergency room physician. We reverse summary judgment dismissal of Davies's informed consent claim and remand for trial. We otherwise affirm.

FACTS

¶2 On August 23, 2017, Davies was involved in a single-car rollover crash. She had no memory of the accident. Paramedics extracted Davies from the vehicle, placed her on a backboard and in a cervical collar, and transported her by ambulance to Good Samaritan Hospital in Puyallup. Davies reported pain in her neck, back, left shoulder, and tingling in her left arm. She also had preexisting high blood pressure, pneumonia, kidney stones, and diabetes.

¶3 Dr. Michael Hirsig, the attending physician at the Good Samaritan emergency room, saw Davies upon arrival. Dr. Hirsig conducted a physical exam and ordered laboratory tests, an electrocardiogram (EKG), and computerized tomography (CT) scans of her head, cervical spine, abdomen, and pelvis. Dr. Scott Henneman, the radiologist who interpreted the CT scans, noted fractures of Davies's cervical spine at the C3 level. At Dr. Henneman's recommendation, Dr. Hirsig contacted Dr. William Morris, a neurosurgeon who often consults by telephone with other physicians in the MultiCare Health System. After reviewing the images, Dr. Morris told Dr. Hirsig that the fractures appeared stable and did not require surgery. Neither Dr. Henneman nor Dr. Morris identified a fracture through the transverse foramen, which would increase the risk of injury to the vertebral artery. Dr. Morris recommended that Davies be placed in a cervical collar for 8 weeks, with a follow-up CT scan to check for healing and alignment. Dr. Morris's progress notes indicate that he was under the impression Davies would be transferred to Tacoma General Hospital for observation by the trauma team.

¶4 Dr. Hirsig initially informed Davies and her family that she had sustained a neck fracture and would likely be transferred to the trauma unit at Tacoma General Hospital. However, after the consultation with Dr. Morris, Dr. Hirsig advised that Davies did not need hospitalization or surgery and could be discharged with a hard cervical collar, with follow-up on an outpatient basis. Dr. Hirsig testified that he asked the family whether they were comfortable taking her home, and they said yes. [1] Dr. Hirsig prescribed pain medication, nausea medication, a muscle relaxant, and a different antibiotic for her pneumonia, and sent Davies home without further treatment or testing.

¶5 The following day, Davies's daughter took Davies to her primary care physician, Dr. Andrew Larsen, for a follow up

visit. Davies's vital signs were unstable and she had severe neck pain made worse by coughing. Dr. Larsen arranged for Davies to be immediately transported to Providence St. Peter hospital for direct admission. While awaiting transport, Davies suffered a stroke in Dr. Larsen's office. Her stroke was later determined to have been caused by a vertebral artery dissection sustained when her neck fractured during the accident. Davies was hospitalized for approximately three weeks and now resides at an assisted living facility.

*2 ¶6 On May 31, 2018, Davies filed suit against MultiCare alleging (1) medical negligence, (2) failure to obtain informed consent, and (3) corporate negligence. Davies alleged that MultiCare and its employees or agents breached the standard of care by failing to admit or transfer her for observation and treatment or by failing to order additional imaging, such as a CT angiography (CTA) scan, to check for vertebral artery dissection prior to discharge. Dr. Hirsig was allowed to intervene on September 14, 2018. On February 13, 2019, Davies filed an amended complaint and added Dr. Hirsig's employer, Mt. Rainier Emergency Physicians PLLC, as a defendant.

¶7 On cross-motions for partial summary judgment, the trial court dismissed Davies's informed consent claim, and the case proceeded to trial on the negligence claims.

¶8 At trial, the jury heard expert testimony regarding whether Dr. Hirsig breached the standard of care of an emergency medicine physician. Dr. Hirsig testified that he considered and rejected a diagnosis of vertebral artery dissection and that his care of Davies met the standard of care. Dr. Raymond Moreno, an emergency medicine physician who practices in Portland, Oregon, testified that Dr. Hirsig "absolutely met the standard of care" by performing a broad workup exam, identifying Davies's neck fracture, and consulting with Dr. Morris prior to making a disposition decision. Dr. Moreno further testified that the standard of care in Washington and Oregon does not require a CTA scan for every C3 fracture.

¶9 Davies's expert Dr. Carrie Tibbles, an emergency physician at Beth Israel Deaconess Medical Center in Boston, testified that her hospital routinely obtains a scan of the vertebral arteries for patients with neck fractures and that when an emergency room physician identifies vertebral artery dissection as a differential diagnosis, the standard of care requires a CTA scan. She further testified that it was not safe for Davies to go home that day.

¶10 Davies also sought to call Dr. Clara Harraher, a neurosurgeon who practices in California, to testify that Dr. Morris breached the standard of care for a neurosurgeon and that Dr. Hirsig breached the standard of care for an emergency room physician. At trial, following the defendants' foundational objection, the trial court ruled that Dr. Harraher could testify to a neurosurgeon's standard of care but not an emergency medicine doctor's standard of care.

¶11 The jury also heard expert testimony regarding whether Dr. Morris breached the standard of care for a neurosurgeon in his consultation with Dr. Hirsig. Dr. Morris described his practice of consulting with other MultiCare physicians regarding neurological issues, and testified that he met the standard of care. Neurologists Dr. David Lundin and Dr. Jeffrey Johnson testified that Dr. Morris's consultation met the standard of care and that not all C3 fractures require vascular imaging.

¶12 Dr. Harraher testified that Dr. Morris's consultation with Dr. Hirsig did not meet the standard of care for a neurosurgeon. She testified that the standard of care required a CTA in this case given the nature of Davies's injuries and the risk of vertebral artery injury.

¶13 Over Davies's objection, the court gave the following "exercise of judgment" jury instruction:

> A physician is not liable for selecting one or two or more alternative diagnoses, if, in arriving at the judgment to make the particular diagnosis, the physician exercised reasonable care and skill within the standard of care the physician was obliged to follow.

¶14 The jury returned a special verdict finding Dr. Hirsig and MultiCare not negligent, and therefore did not reach the issues of proximate cause or damages. The trial court entered judgment against Davies. Davies appealed.

## ANALYSIS

### A. Informed Consent

*3 ¶15 Davies first argues that the trial court erred in dismissing her informed consent claim on summary judgment.[2] This court reviews summary judgment orders de novo. Seybold v. Neu, 105 Wash. App. 666, 675, 19 P.3d 1068 (2001). Summary judgment is appropriate if there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. CR 56(c). All evidence and reasonable inferences are construed in the light most favorable to the nonmoving party. Keck v. Collins, 184 Wash.2d 358, 368, 357 P.3d 1080 (2015).

[1] [2] ¶16 "Informed consent and medical negligence are distinct claims that apply in different situations. While there is some overlap, they are two different theories of recovery with independent rationales." Anaya Gomez v. Sauerwein, 180 Wash.2d 610, 617, 331 P.3d 19 (2014). "Informed consent allows a patient to recover damages from a physician even though the medical diagnosis or treatment was not negligent." Backlund v. Univ. of Wash., 137 Wash.2d 651, 659, 975 P.2d 950 (1999). To prove failure to obtain informed consent, a plaintiff must show:

> (a) That the health care provider failed to inform the patient of a material fact or facts relating to the treatment;
>
> (b) That the patient consented to the treatment without being aware of or fully informed of such material fact or facts;
>
> (c) That a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of such material fact or facts;
>
> (d) That the treatment in question proximately caused injury to the patient.

RCW 7.70.050(1).

[3] [4] ¶17 Washington's informed consent statute is "generally based on the policy judgment that patients have the right to make decisions about their own medical treatment." Backlund, 137 Wash.2d at 663, 975 P.2d 950. "A necessary corollary to this principle is that the individual be given sufficient information to make an *intelligent* decision." Smith v. Shannon, 100 Wash.2d 26, 29, 666 P.2d 351 (1983). "The concept of patient decisionmaking regarding treatment has sometimes been described as 'patient sovereignty.' " Backlund, 137 Wash.2d at 663, 975 P.2d 950 (quoting Archer v. Galbraith, 18 Wash. App. 369, 377 n.2, 567 P.2d 1155 (1977)). "[I]t is for the patient to evaluate the risks of treatment and that the only role to be played by the physician is to provide the patient with information as to what those risks are." Smith, 100 Wash.2d at 30, 666 P.2d 351.

¶18 In Gates v. Jensen, 92 Wash.2d 246, 250, 595 P.2d 919 (1979), a case decided prior to the adoption of RCW 7.70.050(1), our Supreme Court addressed whether the doctrine of informed consent requires a physician to inform a patient of a bodily abnormality and diagnostic procedures that were available to determine the significance of the abnormality. In Gates, the plaintiff complained of difficulty in focusing, blurring, and gaps in vision. Gates consulted an ophthalmologist, Dr. Hargiss, who took eye pressure readings that indicated her eye pressure was in the borderline area for glaucoma. Dr. Hargiss did not conduct further tests and informed Gates that he had checked for glaucoma but found everything all right. Dr. Hargiss did not inform Gates that the high pressure put her at risk for glaucoma, nor that he had available two additional simple, inexpensive, and risk free diagnostic tests for glaucoma.[3] Gates, 92 Wash.2d at 247-48, 595 P.2d 919.

*4 ¶19 At trial, Gates requested jury instructions on the doctrine of informed consent, which the trial court denied. The Supreme Court reversed, explaining:

> Important decisions must frequently be made in many non-treatment situations in which medical care is given, including procedures leading to a diagnosis, as in this case. These decisions must all be taken with the full knowledge and participation of the patient. The physician's duty is to tell the patient what he or she needs to know in order to make them. The existence of an abnormal condition in one's body, the presence of a high risk of disease, and the existence of alternative diagnostic procedures to conclusively determine the presence or absence of that disease are all facts

  

> which a patient must know in order to make an informed decision on the course which future medical care will take.

Gates, 92 Wash.2d at 250-51, 595 P.2d 919.

¶20 At the other end of the spectrum, our Supreme Court has also held that a claim for misdiagnosis does not support a claim for informed consent where the treating physician is unaware of alternative diagnoses. Backlund, 137 Wash.2d at 661, 975 P.2d 950. In Backlund, the defendant physician diagnosed a newborn infant with jaundice and chose to treat the condition with phototherapy rather than a blood transfusion. 137 Wash.2d at 662, 975 P.2d 950. The phototherapy treatment was not successful and the infant suffered brain damage and died. The infant's parents brought medical malpractice and informed consent claims against the treating physician and the University of Washington. A jury exonerated the treating physician and University from negligence for continuing to treat with phototherapy rather than a transfusion. Backlund, 137 Wash.2d at 653, 975 P.2d 950. The trial court found that the possibility of a transfusion was a "material fact" of which the Backlunds were not aware and thus supported their claim for lack of informed consent. The court concluded, however, that the Backlunds failed to prove that a reasonably prudent person would have consented to the treatment even if informed.

¶21 On appeal, the University argued that the Backlunds' claim for lack of informed consent failed as a matter of law because the jury had exonerated the physician from liability for negligence. Our Supreme Court first recognized that negligence and informed consent are "alternative methods of imposing liability on a health care practitioner." And that "[i]nformed consent allows a patient to recover damages from a physician even though the medical diagnosis or treatment was not negligent." Backlund, 137 Wash.2d at 659, 975 P.2d 950. The court explained further:

> A physician who misdiagnoses the patient's condition, and is therefore unaware of an appropriate category of treatments or treatment alternatives, may properly be subject to a negligence action where such misdiagnosis breaches the standard of care, but may not be subject to an action based on failure to secure informed consent.

Backlund, 137 Wash.2d at 661, 975 P.2d 950.

¶22 The Supreme Court disagreed with the University's position that the Backlunds' informed consent claim failed as a matter of law. The court concluded that even though the jury found no negligence, because there were no facts suggesting that the treating physician was unaware of the transfusion alternative, the "trier of fact might still have found he did not sufficiently inform the patient of risks and alternatives in accordance with RCW 7.70.050." Backlund, 137 Wash.2d at 662, 975 P.2d 950. The Supreme Court agreed with the trial court, however, that the Backlunds failed to demonstrate that a reasonably prudent person would have consented to the treatment even if informed. Backlund, 137 Wash.2d at 668, 975 P.2d 950.

*5 ¶23 More recently, in Anaya Gomez, our Supreme Court again discussed the interplay between informed consent claims and negligence claims based on misdiagnosis. 180 Wash.2d at 613, 331 P.3d 19. In Anaya Gomez, the physician did not alert a diabetic patient to preliminary blood test results indicating that she had a yeast infection, having concluded that it was a false positive because the patient indicated that she was feeling better. 180 Wash.2d at 613-14, 331 P.3d 19. A later test confirmed the presence of a severe yeast infection. Anaya Gomez, 180 Wash.2d at 615, 331 P.3d 19. After the patient died, her personal representative brought claims for negligence and informed consent. The trial court dismissed the informed consent claim on summary judgment, and the Supreme Court affirmed.

¶24 The Supreme Court began by setting forth the issue before it: "[i]n determining which theory of recovery is available, the issue is whether this is a case of misdiagnosis subject only to negligence or if the facts also support an informed consent claim." Anaya Gomez, 180 Wash.2d at 617, 331 P.3d 19. The court explained that it was significant in Gates

that the ophthalmologist had "two additional diagnostic tests for glaucoma which are simple, inexpensive, and risk free." Anaya Gomez, 180 Wash.2d at 621, 331 P.3d 19 (quoting Gates, 92 Wash.2d at 248, 595 P.2d 919). Consequently, the "choice the ophthalmologist could have put to Mrs. Gates was whether to do the additional testing in light of her borderline test result. Given the small cost and effort of those tests, the decision was relatively easy." Anaya Gomez, 180 Wash.2d at 621, 331 P.3d 19.

¶25 The court distinguished the situation before it from the situation in Gates, determining that "[t]his case is different from Gates because there was nothing else that Dr. Sauerwein could have done. Informing a patient about a likely erroneous lab result gives the health care provider nothing to ' "put to the patient in the way of an intelligent and informed choice." ' " Anaya Gomez, 180 Wash.2d at 622, 331 P.3d 19 (quoting Keogan v. Holy Family Hospital, 95 Wash.2d 306, 330, 622 P.2d 1246 (1980) (Hicks, J., concurring in part, dissenting in part)). Because Gates did not apply, the court applied the "Backlund rule" and affirmed the trial court's dismissal of the informed consent claim as a matter of law. Anaya Gomez, 180 Wash.2d at 623, 331 P.3d 19.

¶26 Important here, the court confirmed that Gates has not been overruled. Anaya Gomez, 180 Wash.2d at 623, 331 P.3d 19. The court explained:

> Backlund and Keogan state the general rule of when a plaintiff can make an informed consent claim. The Gates court allowed the informed consent claim based on a unique set of facts that are distinguishable from this case. Under Gates, there may be instances where the duty to inform arises during the diagnostic process, but this case does not present such facts. The determining factor is whether the process of diagnosis presents an informed decision for the patient to make about his or her care. Dr. Sauerwein's knowledge of the test result provided no treatment choice for Mrs. Anaya to make.

Anaya Gomez, 180 Wash.2d at 623, 331 P.3d 19.

**[5]** ¶27 Here, like Gates, and unlike Anaya Gomez, Davies presented evidence at summary judgment supporting that once she was correctly diagnosed with a cervical fracture, there were additional tests available as part of her initial diagnoses—namely a CT angiography (CTA) scan—to check for vertebral artery dissection prior to discharge. Davies's medical experts testified that vertebral artery injury is a "common" and "well known" occurrence following cervical spine fractures. As Davies's expert Dr. Harraher testified in deposition:

> Q. Doctor, if I understand you correctly, the reason that there is a whole body of literature on the fact that you should screen for vertebral artery injury when you have a cervical spine fracture is because those are commonly found?
>
> ***6** A. Yes.
>
> Q. They are commonly found together and commonly missed; right?
>
> A. Correct.

Davies's expert Dr. Becker similarly testified:

> Q. What's the basis of the opinion that this fracture should have prompted imaging of her cervical arterial vessels?
>
> A. It's well-known in the trauma literature that the mechanism of injury that leads to a cervical fracture is one that can also lead to a cervical arterial dissection, and there are criteria that have been created that suggest that if someone has such a fracture that they should have cervical arterial imaging.

¶28 Davies further presented evidence at summary judgment that had she undergone a CTA, her vertebral artery dissection would have been diagnosed and a different treatment regimen other than sending her home in a neck brace would have been initiated, preventing her subsequent stroke. Dr. Becker explained:

Q. And then what do you believe that the treatment of either aspirin, Plavix, or heparin would have prevented, if anything?

A. I believe that it would have prevented her subsequent stroke.

Q. And what's the basis of the opinion that aspirin, Plavix, or heparin would have prevented her stroke?

A. If you look at all the studies that have been done of antithrombotic therapy in arterial dissections, they are all highly effective with very few patients ever going on to have a recurrent event, or an event if it was a dissection that was picked up kind of prophylactically.

¶29 Davies's medical expert, Dr. Tibbles, agreed:

Q. Okay, as far as causation opinions go in this case, you offered causation testimony that had Doctor Hirsig and Doctor Morris somehow through that process admitted her to trauma service, then she would not have suffered a stroke? Did I understand your causation opinion?

A. I believe more likely than not if she had received proper comprehensive care from a trauma team, including a neurosurgeon and the proper evaluation of her condition, that more likely than not they would have done the right thing and worked up the cervical spine fracture in the proper way, which would have included evaluation of the vessels.

Had the vessels been evaluated, the dissection seen, the potential—there's a window there to treat the stroke—treat the potential complications of stroke and therefore prevent the stroke.

**[6]** ¶30 Viewed in the light most favorable to Davies, as we must, her experts agree that had she undergone a CTA, she would have been diagnosed with a vertebral artery dissection, which then would have been treated, preventing her from having a stroke the next day. Davies was never advised of the risk of a vertebral artery dissection or the availability of a CTA scan to look for the injury which would have led to a different treatment. Like Gates, and unlike Anaya Gomez, there were diagnostic and treating procedures available to the treating doctors. As the Supreme Court recognized in Anaya Gomez, "the determining factor is whether the process of diagnosis presents an informed decision for the patient to make about his or her care." 180 Wash.2d at 623, 331 P.3d 19. Here, there was. Summary judgment dismissal of Davies's informed consent claim was erroneous.

B. Jury Instruction

***7** **[7]** ¶31 Davies argues next that the trial court erred by giving an exercise of judgment instruction to the jury because the instruction is appropriate only where there is evidence that the physician makes a choice between alternative diagnoses. Davies contends that the trial record is devoid of evidence to support the jury's determination that Dr. Hirsig and MultiCare made such a choice. We disagree.

**[8]** **[9]** ¶32 We review a decision on whether to give an exercise of judgment instruction for abuse of discretion. Fergen v. Sestero, 174 Wash. App. 393, 396, 298 P.3d 782 (2013), aff'd, 182 Wash.2d 794, 803, 346 P.3d 708 (2015). This is a fact specific inquiry. Fergen, 182 Wash.2d at 803, 346 P.3d 708. Jury instructions are generally sufficient if they: (1) are supported by the evidence; (2) allow each party to argue its theory of the case; and (3) properly inform the trier of fact of the applicable law when all the instructions are read together. Fergen, 182 Wash.2d at 803, 346 P.3d 708.

¶33 Our Supreme Court considered use of the exercise of judgment instruction most recently in Fergen. Fergen involved a consolidated appeal from two medical malpractice trials in which the trial court gave an exercise of judgment instruction and the jury returned a verdict for the defendants. In the first case, Fergen, Paul Fergen presented to the physician with a lump on his ankle. After performing a physical examination and taking an x-ray of the ankle, the physician diagnosed the lump as a benign cyst and referred him to an orthopedic office without conducting further testing. Fergen, 182 Wash.2d at 799, 346 P.3d 708. In doing so, the physician chose to forgo an ultrasound on Fergen's ankle, which may have found the rare form of cancer that began in Fergen's ankle and resulted in his death. Fergen, 182 Wash.2d at 799-800, 346 P.3d 708.

¶34 In the second case, Appukuttan v. Overlake Medical Center, Anil Appukuttan injured his leg during a soccer game. He visited the emergency room five times due to increasing pain in his leg. Multiple physicians examined him, but none measured the pressure in his leg to rule

out compartment syndrome, instead believing his symptoms indicated a different diagnosis. Fergen, 182 Wash.2d at 801, 346 P.3d 708. Appukuttan "suffered permanent foot drop injury as a result of the failure to diagnose and treat his compartment syndrome." Fergen, 182 Wash.2d at 801, 346 P.3d 708.

¶35 In a split 5-4 decision, the majority first concluded that the instruction was supported under Washington law. The court also rejected an invitation to overrule precedent and abandon use of the instruction as unnecessary. Fergen, 182 Wash.2d at 803-05, 809-11, 346 P.3d 708.[4] Turning to the merits, the court held that for Fergen, the physician "had a choice between referring Fergen to a specialist or not ... ordering an X ray or not[, and] ordering follow up testing or not." Fergen, 182 Wash.2d at 808, 346 P.3d 708. For Appukuttan, the court concluded that the physicians decided that the pressure test "was unnecessary because their physical examination did not indicate that compartment syndrome was the diagnosis." Fergen, 182 Wash.2d at 809, 346 P.3d 708.

***8 [10]** ¶36 In reaching its holding, the Supreme Court explained:

> In Washington, an exercise of judgment instruction is justified when (1) there is evidence that the physician exercised reasonable care and skill consistent with the applicable standard of care in formulating his or her judgment and (2) there is evidence that the physician made a choice among multiple alternative diagnoses (or courses of treatment).

Fergen, 182 Wash.2d at 806, 346 P.3d 708. As this court recently summarized:

> Specifically, a court should give the instruction only when the physician presents sufficient evidence that they made a choice between two or more alternative, "reasonable [and] medically acceptable" treatment plans or diagnoses. The court should not give the instruction "simply if a physician is practicing medicine at the time." The Fergen Court also recognized an exception to the instruction's use: A court should not give the exercise of judgment instruction in cases focusing on the inadequate skills of the physician.

Needham v. Dreyer, 11 Wash. App. 2d 479, 488-89, 454 P.3d 136, review denied, 195 Wash.2d 1017, 461 P.3d 1201 (2020) (quoting Fergen, 182 Wash.2d at 808, 346 P.3d 708).

¶37 Applying the Fergen standard to the testimony at trial, we conclude that the exercise of judgment instruction in this case was proper. Dr. Hirsig testified that he considered the possibility that Davies could have a vertebral artery dissection in making his differential diagnosis. After consulting with Dr. Henneman, the neuroradiologist that reviewed Davies's CT scan, he learned that she had a C3 fracture of her cervical spine, but Dr. Henneman did not identify a fracture of the transverse foramen. Such a fracture would have heightened Dr. Hirsig's awareness that there could be an injury to the vertebral artery. Consequently, Dr. Hirsig chose not to request a CTA to test for vertebral artery dissection because he believed the likelihood she did not have one outweighed the likelihood she did not. He summarized:

> with my assessment of the patient, with her physical findings and with her exam and with all the information I had, and in speaking to the neuroradiologist as well as the neurosurgeon [Dr. Morris], the consensus—I felt like that [vertebral arterial dissection] was not something I needed to further assess.

¶38 Neurosurgeon Dr. Morris, also testified that in consulting with Dr. Hirsig, he reviewed Ms. Davies's CT images and specifically looked for a fracture of the transverse foramen in the C3 area because the risk of injury to the vertebral artery is higher with such a fracture. Dr. Morris observed no sign of a fracture to the transverse foramen. And finally defense experts testified that both physicians met the standard of care in deciding not to order a CTA scan. Consistent with the standard set out in Fergen, the testimony supported that Dr. Hirsig and Dr. Morris, considered the possibility of a

diagnosis of vertebral arterial dissection and made a choice not to pursue further.

¶39 Davies argues that this court's recent opinion in Needham compels reversal. Needham is distinguishable. In Needham, the plaintiff visited his primary care doctor complaining of breathing problems and gastrointestinal issues. 11 Wash. App. 2d at 481, 454 P.3d 136. The physician treated him for his preexisting HIV and diarrhea, but did not address his breathing problems. Needham, 11 Wash. App. 2d at 481, 454 P.3d 136. Several days later he was found unconscious in cold weather, resulting in frostbite that required amputation. Needham, 11 Wash. App. 2d at 481, 454 P.3d 136. The plaintiff sued his physician and the clinic alleging medical negligence as the cause of his injuries. Needham, 11 Wash. App. 2d at 481-82, 454 P.3d 136. Over his objection, the trial court gave an exercise of judgment instruction and the jury entered a verdict for the defense. Needham, 11 Wash. App. 2d at 486, 454 P.3d 136. This court, applying Fergen, held that the exercise of judgment instruction was improper because there was no evidence that the physician actually made a choice in diagnosing or treating his breathing problems. But here, unlike Needham, there was evidence that the physicians considered and actively chose among alternative diagnoses and treatment plans.

***9** ¶40 We conclude that based on the standard approved in Fergen and the testimony presented, the trial court did not abuse its discretion in giving the exercise of judgment instruction.

C. Expert Witness

**[11]** ¶41 Davies argues finally that the trial court abused its discretion by preventing Dr. Harraher, a neurosurgeon, from testifying regarding the standard of care for Dr. Hirsig, an emergency room physician. We agree, but conclude the error was harmless.

**[12]** ¶42 We review the decision to exclude an expert witness's testimony for abuse of discretion. Driggs v. Howlett, 193 Wash. App. 875, 896, 371 P.3d 61 (2016). Discretion is abused if it is exercised on untenable grounds or for untenable reasons. Morin v. Burris, 160 Wash.2d 745, 753, 161 P.3d 956 (2007).

**[13]** ¶43 "[E]xpert testimony will generally be necessary to establish the standard of care and proximate cause required in medical malpractice cases." Berger v. Sonneland, 144 Wash.2d 91, 111, 26 P.3d 257 (2001). The plaintiff must show that the health care provider "failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances." RCW 7.70.040(1).

**[14]** **[15]** **[16]** **[17]** ¶44 Only experts who practice in the same field or have expertise in the relevant specialty may establish the standard of care. McKee v. Am. Home Prods., Corp., 113 Wash.2d 701, 706, 782 P.2d 1045 (1989). "The scope of the expert's knowledge, not his or her professional title, should govern 'the threshold question of admissibility of expert medical testimony in a malpractice case.' " Hill v. Sacred Heart Med. Ctr., 143 Wash. App. 438, 447, 177 P.3d 1152 (2008) (quoting Pon Kwock Eng v. Klein, 127 Wash. App. 171, 172, 110 P.3d 844 (2005)). "A physician with a medical degree is qualified to express an opinion on any sort of medical question, including questions in areas in which the physician is not a specialist, so long as the physician has sufficient expertise to demonstrate familiarity with the procedure or medical problem at issue in the medical malpractice action." Hill, 143 Wash. App. at 447, 177 P.3d 1152 (quoting Morton v. McFall, 128 Wash. App. 245, 253, 115 P.3d 1023 (2005)). When experts are from a different school of medicine, the testimony should be allowed "(1) where the methods of treatment in the defendant's school and the school of the witness are the same, (2) where the method of treatment in the defendant's school and the school of the witness should be the same, or (3) the testimony of a witness is based on knowledge of the defendant's own school." Leaverton v. Cascade Surgical Partners, P.L.L.C., 160 Wash. App. 512, 519, 248 P.3d 136 (2011).

¶45 We conclude that Dr. Harraher had sufficient expertise in the procedures and medical problem at issue to testify regarding the standard of care in Davies's case. Dr. Harraher completed a cerebrovascular fellowship at Stanford, including work regarding the vertebral artery. She testified that she has substantial emergency room experience,

including the care and treatment of patients with neck fractures and the decision to order a CTA scan. Similarly, in Eng, this court held that an infectious disease doctor was qualified to testify regarding a neurosurgeon's failure to diagnose meningitis, where the expert's knowledge of the medical problem was uncontested and the defendant's method and failure to properly diagnose was not particularized to his neurological specialty.

*10 [18] [19] [20] ¶46 However, even if the trial court erred in excluding this testimony, reversal is not required because the error was harmless. The test for harmless error is whether there is a reasonable probability that the error materially affected the outcome of the trial. Frantom v. State, 12 Wash. App. 2d 953, 959, 460 P.3d 1100 (2020). "A factor to consider when determining harmless error is whether excluded evidence involved cumulative evidence." Driggs, 193 Wash. App. at 903, 371 P.3d 61.

¶47 As an offer of proof, counsel for Davies stated that Dr. Harraher would have testified that Dr. Hirsig should not have discharged Davies due to the mechanism of her injury and the other clinical problems that she was having. But Davies's emergency medicine expert, Dr. Tibbles, testified extensively as to her opinion that Davies was not safe to go home and should not have been discharged. Because the excluded testimony was cumulative, reversal is not required.

¶48 We reverse summary judgment dismissal of Davies's informed consent claim and remand for trial. We otherwise affirm.

WE CONCUR:

Coburn, J.

Dwyer, J.

**All Citations**

--- P.3d ----, 2021 WL 2909042

## Footnotes

1 Davies's daughter Melissa Brononske disputed Dr. Hirsig's testimony that the family agreed with the discharge decision.

2 In her opening brief, Davies expressly states that her corporate negligence claim against MultiCare and vicarious liability claim against Mt. Rainier were not at issue in this appeal. The claims are therefore abandoned.

3 The first was to use standard drops for dilating the pupils to obtain a better view of the optic nerve. The second was to have Gates take a "visual field examination" to determine if she had suffered any loss in vision. Gates, 92 Wash.2d at 248, 595 P.2d 919.

4 The dissent concluded that the exercise of judgment law was rooted in the discredited "error of judgment" instruction and not supported by Washington law; that the instruction is confusing, unfair, and inconsistent with the modern practice of giving neutral instructions; and that the instruction should be disapproved of. Fergen, 182 Wash.2d at 812-26, 346 P.3d 708 (Stephens, J., dissenting). While the dissent in Fergen is compelling, we are bound by the majority opinion.

## SMITH GOODFRIEND, PS

## August 10, 2021 - 4:11 PM

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